Rhythm of Peace Therapeutic Services Referral Form

Baltimore, MD

410-807-3380

Referral Source

Referring Agency
Address:_____
_____

Name of Referrer:_____ Referral Source Email:_____

Phone Number:_____

Consumer Information

Full Name:_____

DOB:_____ Gender:_____

Race:_____ SSN:_____ Medical Assistance #_____

Address:_____
_____ Zip Code: _____

Phone Number:_____ Email :_____

Consumer Availability: _____

Does Consumer speak English:___ Yes ____No Is consumer Hispanic, Latino, or Spanish origin: ____Yes ___No

Has consumer been arrested in the last 30 days? ___Yes ___No

Current Medications (please include name and dosage):

_____
_____
_____

Has the consumer recently been discharged from therapy services? _____ Yes _____No

Is the consumer a Veteran? _____ Yes _____No

If Consumer is a Child:

Legal Guardian Name:_____ Relationship to consumer:_____

Is consumer a foster child? _____Yes _____No (If yes, please provide a copy of the court order)

School: ____Yes ____No Grade:_____ IEP:_____

Health Insurance

Insurance Provider:_____Insurance #: _____

Services Requested:

___Mental Health Evaluation/Assessment ___Medication Management ___Individual/Family/Group Therapy

___Psychiatric Rehabilitation Services (PRP) Referral

Reason For Referral/Presenting Problem: *(In your own words, please describe consumer's need for therapy service. Please describe specific behaviors the adult/child is exhibiting. Please specifically explain any of the following in relation to the client in the past or present: Suicide ideation, self harm, aggression, Mood Related Symptoms, Domestic Violence, Psychotic Symptoms, Substance Abuse, Recent hospitalizations, or violence towards others)*

_____
_____
_____
_____
_____